EFFECT OF QUALITY CONTROL PROGRAMS ON THE ORGANIZATIONAL STRUCTURE OF THE HOSPITALS*

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As Claude Welch stated, when then-President Richard Nixon signed Public Law 92-603 establishing Professional Standards Review Organizations (PSROs), "He formed a basis for greater changes in the practice of medicine than had been provided by any health legislation in the history of this country."[1] In response to this legislation health professionals are designing and developing systems of quality control primarily in order to conform with government regulations.

We may fail to recognize the opportunity that such a system affords to improve the care of patients at the level of the individual physician and patient as well as the more complex organizational level of the hospital. A major problem of hospitals is the need to achieve maximal organizational effectiveness and, thereby, to enhance management. The structural unit that can accomplish this task, the medical staff organization, exists in all hospitals in the United States. With the application of rational management principles, the organized medical staff could develop into an orderly but flexible system which is integrated into the total hospital organization and which provides the maximum opportunity 1) to stimulate change in response to needs and 2) to increase the efficient use of medical-care resources required to meet the needs which are defined.

Major alterations in the hospital's system of government and management are not necessary. What is necessary is, first, to define organizational authority within the hospital and to ensure that responsibility is accepted; second, to maximize involvement of the medical staff in

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the decision-making process; and, third, to establish an effective and efficient system in the hospital to provide information to management.

Organizational relations between the components of the hospital (the board of trustees, the administration, and the medical staff) have been firmly established but not so firmly accepted. The medical staff is not merely a group of independent practicing physicians. It exists as an organizational and corporate body of the hospital, with its authority delegated and its functions assigned by the board of trustees. The jurisdiction of the medical staff has been defined as 1) the delivery of medical services and 2) the evaluation of medical services. A universal issue which involves these organizational relations is the major change in attitudes toward authoritarian control taking place today. Established authoritarian systems have been challenged by the "doers," especially professional persons who are dissatisfied with the inflexible environment in which they are expected to function. Involvement in the process of governance has become a demand of the governed: "All members of organizations, especially key professionals, are coming to expect that they will have more to say in the decision-making in their organization."[2] Justification for this demand is supported by studies of organizational behavior. Involvement or participation of the person doing the job is characteristic of the decision-making process that promotes organizational effectiveness.[2, 3] This principle is common to many areas of human behavior—learning (programs of continuing medical education,[4, 5] for example), the process of planned change,[8] management,[2, 6, 7] and quality control.[9]

The participative system of management which has been proposed conforms to McGregor's decision-making "theory Y," in contrast to the traditional authoritarian model ("theory X") in which decisions filter down from a higher level in the hierarchy of authority.[7] Proponents of this participatory style of management have demonstrated that involvement leads to 1) higher motivation, 2) greater productivity, 3) more willingness to accept decisions, 4) acceptance of responsibility, and 5) greater commitment to the objectives of the institution. Mayo's studies of organizational behavior at the Western Electric plant in Hawthorne, Ill., in the 1930s established that people will work hard, even in the face of adverse working conditions, if they consider the objective to be worthwhile.[6]

The legislators who framed the PSRO component of P.L. 92-603

recognized the need for local review and responsibility. Included in the law is Section 1155(e), which provides for "delegated review" to the medical staffs of those hospitals who operate an effective quality-control program.

Which components of medical care should be represented in the development of a program to manage the care of patients or to control the quality of care? Of critical importance is the participation of those physicians, nurses, and therapists who have responsibility for and interact directly with the individual patient. Included in this group are attending and consulting physicians, floor nurses, and physical or respiratory therapists.

This category of health professionals is responsible for the bulk of medical transactions. They are the "doers," they translate decisions into actions in the care of patients, and it is their performance which is subject to review. Too many of today's decisions in the care of patients are being made by administrative professionals, the "thinkers," who are located far from the action. Effectiveness in the implementation of managerial decisions, I believe, is related inversely to the distance of the doers from the patients.

If we are to achieve meaningful changes in the delivery of health, according to P. A. Tumulty, leadership "must be provided by those whose primary interest and education is in clinical medicine, for others would not perceive the problems or the solutions nearly so aptly." He continues, "In a clinical . . . undertaking, Administration should be the strong right arm which supports those who do the patient care, . . . but it should never become the head which sets goals and determines policy.[10]

Consumers of medical care are demanding a voice in the management of their care; this should be encouraged. Consumers are a major component of the medical-care complex. Active participation by consumers at the local (community hospital) level in all phases of the quality-control process (including the setting of standards and the review and analysis of performance) will lead to appropriate changes. The acquisition of an increased depth of understanding by members of the public could help to narrow the gap between their expectations and what medicine can accomplish by substituting hard facts and cost-benefit analysis for existing attitudes and beliefs like those fostered by Marcus Welby.

The patient is more likely to accept the cost of quality care if he has an understanding of the cost of that quality and if he has been involved in determining the priorities for the allocation of the health resources available within his own community. Likewise, consumers, working with professionals, could have a significant influence upon the planners and designers of administrative programs in the legislative and regulatory bureaucracies.

Finally, participation by the consumer in defining the objectives of his medical-care organization could increase credibility, since, according to Donabedian,[11] "There is . . . a serious question about whether medical care organizations primarily serve the interests and wishes of the clients as seen by the clients themselves or those interests as interpreted by the professional and other elites who determine medical care policy."[11]

The elements of a system to manage the care of patients as described thus far include the *where*—the medical staff organization, the *what*—participative management, and the *who*—clinical professionals and consumers. The *how* might well constitute the most significant contribution of Public Law 92-603 to the care of patients. The fundamental need to make effective decisions is common to all programs to control quality, including foundations for medical care, the American Hospital Association's quality assurance program, evaluation studies of medical care, utilization-review regulations, and PSRO regulations.

Three functions are essential to any effective quality-control system: 1) the formulation of criteria, 2) the ability to analyze data that actually measures the care provided and the results of that care, and 3) the feedback of performance data to effect corrective change or to reinforce acceptable behavior.

The criteria to evaluate medical care—the identifiable elements defining the necessity for, appropriateness of, and quality of care—are the basis for management planning. Since the planning process is directed toward making the most effective use of the hospital's resources to accomplish an organizational objective, the formulation of criteria for medical care becomes an integral part of the process of defining organizational plans. Within the limitations of our present knowledge, categorically specific objectives for managing the care of patients can be developed which will define responsibilities of the clinical professional for the delivery of medical care. These responsi-

bilities, according to Kerr White, are to "identify, prevent, ameliorate or resolve health problems of individual persons and populations. . . ." [12] The development of such objectives also will help to utilize the hospital facilities and services most efficiently. In this setting the consumer-participant is exposed to the realities of the care of patients—where he can learn what is achievable.

The ability to measure and analyze the care which is actually provided and to compare the results of that care with preset criteria is the keystone of the information system for managing the care of patients. The importance of a structured system for the analysis of data cannot be overemphasized, because 1) it permits data to be displayed in a form which is easily understood by all parties, 2) it measures the effectiveness of organizational plans and programs, and 3) it allows decisions to be based upon explicit value judgments.

This feedback of information plus the decisions for action which are derived from the analysis to the appropriate organizational unit provides the basis for planned change. The availability of data on performance makes it possible to identify whose behavior needs to be changed as well as the direction and method for corrective action. In addition, the availability of appropriate information for making decisions enhances the acceptance of assigned responsibility, as illustrated by the following example of the actions of the medical staff executive committee of a 541-bed community hospital.

Information from the hospital's quality-assurance system had pointed to the inappropriate use of beds by Dr. Y. The average length of stay for Dr. Y's patients in two diagnostic categories plus one operative category exceeded by 6.3 days that of his peers in the same surgical subspecialty. The utilization committee, having no punitive powers and recognizing Dr. Y's recalcitrant nature, referred the problem to the executive committee. The latter, confirming Dr. Y's continued recalcitrance, threatened him with suspension from the medical staff if at the end of four months he failed to demonstrate compliance consistent with the performance of his peers. At the end of the designated period the average stay of Dr. Y's patients decreased by 6.9 days to a level consistent with that of his peers. Presented with information known to be valid and reliable, the executive committee accepted the responsibility for using its authority; this resulted in changes in the behavior of an uncooperative colleague.

The response of nonmedical persons (consumers) to similar structured information can be equally effective in producing meaningful change. Of 85 patients with the diagnosis of stroke who were studied, only an embarrassing 4% had complied with the criterion for bedside rehabilitative therapy as administered by the nursing staff. Deficiencies in the performance of primary physicians, floor nurses, and physical therapists were readily identified when the data was analyzed at a meeting of the medical department in which all of these health personnel participated. It was found that each was unaware of the other's role and there was no team organization. The conference resulted in a recommendation for a new position—a nurse rehabilitation coordinator —who would integrate the hospital's rehabilitation services. The presentation of the results of this study and recommendations to the board of trustees at a meeting of the joint conference committee evoked prompt and favorable action. The recommendation was approved by the finance and personnel committees and the entire board within three weeks—an institutional record! Meaningful and understandable data had stimulated organizational change in response to a demonstrated need.

Equally important, the feedback of data on performance also can be used to reinforce identified acceptable behavior. All too frequently, individuals whose performance has been reviewed and found to be at an optimum level are unaware of the "good news." The satisfaction of knowing they are providing the quality of care implied by the criteria can reinforce their efforts. Likewise, the feedback of the documented excellence of care to and by the consumer (since he is part of the system) is a "means for assuring the public and their representatives that optimal health care is in effect being provided."[13] Presentations to consumer groups in our community of data showing a 98 to 100% compliance with criteria justifying specific surgical operations (cholecystectomy, cesarean section, hysterectomy) have successfully countered reports in the New York press of the prevalence of unnecessary surgery.

The methods of quality control thus provide a framework for a practical system of information for managing the care of patients. The systematic provision of valid and useful data is necessary if we are to integrate the decision-making activities of clinical professionals, administrators, and consumers in the management of both individual patients and aggregates of patients. The free flow of ideas and information can

occur only in a structured system. Without a structured system, the opportunity to enhance the management of and directly improve the care of patients—both at the individual physician-patient level and at the hospital level—may well be lost, a loss that our profession can ill afford.

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